Medical Fraud

Challenging The Aids Myths

A Collection Of Articles About HIV Dissidence And The Fight To Survive AIDS.

Medical Fraud: Challenging The AIDS Myths.
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AIDS- Challenging the Myths.

Increasing numbers of health specialists, researchers and scientists are coming to question the current AIDS orthodoxy and assert that HIV does not necessarily equal AIDS and certainly does not mean death. Rather than being the product of a virus, these dissidents see Acquired Immune Deficiency Syndrome as the result of an unhealthy lifestyle. A polluted environment, the use of recreational and anti viral drugs, stress, poverty and other factors work together to ruin the body's natural immunity. Whilst some dissidents believe the HIV virus may be a factor, others believe it is actually harmless whilst some dispute its existence altogether. However what they all agree on is that research into the causes of AIDS has failed to address major inconsistencies or to explore alternative causes outside of HIV. As a result they believe that the administration of toxic anti-viral drugs to people with HIV is destroying their health and that alternative, immune-building therapies are what is required to beat AIDS. Furthermore they contend that the way to prevent AIDS is to avoid immune destroying drugs, to lead a healthy lifestyle and to avoid debilitating disease where possible (this includes practicing safe sex to avoid STDs).

We believe that the issues raised here pose important questions for the way we have dealt with AIDS, particularly in the sphere of campaigning and activism. AIDS activists and People Living With AIDS groups such as ACT UP San Francisco, Keep Hope Alive and some HEAL chapters are among those who have turned their activities away from promoting dangerous anti-viral drugs and towards demanding answers and solutions to a toxic lifestyle and society. Some have even begun suing pharmaceutical conglomerates for poisoning them and reducing their lifespan through the sale of AZT.

We also feel that the issues AIDS dissidence raises require us to confront the society we live in and the way it destroys the health of people across the world- particularly in non western countries through the imposition of poverty, war, environmental destruction, agribusiness and non wholistic healthcare. Sadly in Australia AIDS lobby groups have failed to ask these questions with most of the gay and mainstream press choosing to suppress stories and findings contrary to the AIDS orthodoxy.

In publishing this collection of articles we hope to help further the challenge to the AIDS orthodoxy that these writers and others have begun. As with all ideas we are not asking you to blindly accept all that is proposed, but to consider them and act on them if you feel they are true. Ideas are best chewed, not swallowed whole.

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What causes AIDS?
It's an open question.

By Charles A. Thomas Jr., Kary B. Mullis, & Phillip E. Johnson

Reason June 1994

Most people believe they know what causes AIDS. For a decade, scientist, government officials, physicians, journalists, public-service ads, TV shows, and movies have told them that AIDS is caused by a retrovirus called HIV. This virus supposedly infects and kills the "T-cells" of the immune system, leading to an inevitably, fatal immune deficiency after an asymptomatic period that averages 10 years or so. Most people do not know-because there has been a virtual media blackout on the subject-about a longstanding scientific controversy over the cause of AIDS, controversy that has become increasingly heated as the official theory's predictions have turned out to be wrong.

Leading biochemical scientists, including University of California at Berkeley retrovirus expert Peter Duesberg and Nobel Prize winner Walter Gilbert, have been warning for years that there is no proof that HIV causes AIDS. The warnings were met first with silence, that has been with us for centuries without causing an epidemic.

No one disputes what happens in the early stages of HIV infection. As other viruses do, HIV multiplies rapidly, and it sometimes is accompanied by a mild, flu-like illness. At this stage, while the virus is present in great quantity and causing at most mild illness in the ordinary way, it does no observable damage to the immune system. On the contrary, the immune system rallies as it is supposed to do and speedily reduces the virus to negligible levels. Once this happens, the primary infection is over. If HIV does destroy the immune system, it does so years after the immune system has virtually destroyed it. By then the virus typically infects very few of the immune system' s T-cells.

Before these facts were well understood, Robert Gallo and his followers insisted that the virus does its damage by directly infecting and killing cells. In his 1991 autobiography, Gallo ridiculed HIV discoverer Luc Montagnier's view that the virus causes AIDS only in the company of as yet undiscovered "cofactors." Gallo argued that "multifactorial is multi-ignorance" and that, because being infected by HIV was "like being hit by a truck," there was no need to look for additional causes or indirect mechanisms of causation.

All that has changed. As Warner C. Greene, a professor of medicine at the University of California, San Francisco, explained in the September 1993 *Scientific American*, researchers are increasingly abandoning the direct cell-killing theory because HIV does not infect enough cells: "Even in patients in the late stages of HIV infection with very low blood T4 cell counts, the proportion of those cells that are producing HIV is tiny-about one in 40. In the early stages of chronic infection, fewer than one in 10,000 T4 cells in blood are doing so. If the virus were killing the cells just by directly infecting them, it would almost certainly have to infect a much larger fraction at any one time."

Gallo himself is now among those who are desperately looking for possible co-factors and exploring indirect mechanisms of causation. Perhaps the virus somehow causes other cells of the immune system to destroy T-cells or induces the T-cells to destroy themselves. Perhaps HIV can cause immune-system collapse even when it is no

longer present in the body. As Gallo put it at an AIDS conference last summer: "The molecu mimicry in which HIV imitates components of the immune system sets events into motion that may be able to proceed in the absence of further whole virus."

But researchers have not been able to confirm experimentally any of the increasingly exotic causal mechanisms that are being proposed, and they do not agree about which of the competing explanations is more plausible. When *The New York Times* interviewed the government' s head AIDS researcher, Anthony Fauci, in February, reporter Natalie Angier summarized his view as a sort of stew of all the leading possibilities: "It [HIV] overexcites some immune signaling pathways, while eluding the detection of others. And though the main target of the virus appears to be the famed helper T-cells, or CD-4 cells, which it can infiltrate and kill, the virus also ends up stimulating the response of other immune cells so inappropriately that they eventually collapse from overwork or confusion." No other virus is credited with such a dazzling repertoire of destructive skills.

Perhaps it is the HIV scientists who are collapsing from overwork or confusion. The theory is getting ever more complicated, without getting any nearer to a solution. This is a classic sign of a deteriorating scientific paradigm. But as HIV scientists grow ever more confused about how the virus is supposed to be causing AIDS, their refusal to consider the possibility that it may not be the cause is as rigid as ever. On the rare occasions when they answer questions on the subject, they explain that "unassailable epidemiological evidence" has established HIV as the cause of AIDS. In short, they rely on correlation.

The seemingly close correlation between AIDS and HIV is largely an artifact of the misleading definition of AIDS used by the U.S. government' s Centers for Disease Control. AIDS is a syndrome defined by the presence of one or more of 30 independent diseases-when accompanied by a positive result on a test that detects antibodies to HIV. The same disease conditions are not defined as AIDS when the antibody test is negative. Tuberculosis with a positive antibody test is AIDS; tuberculosis with a negative test is just TB.

The skewed definition of AIDS makes a close correlation with HIV inevitable, regardless of the facts. This situation was briefly exposed at the International AIDS Conference in Amsterdam in 1992, when the existence of dozens of suppressed "AIDS without HIV" cases first became publicly known. Instead of considering the obvious implications of these cases for the HIV theory, the authorities at the CDC, who had known about some of the cases for years but had kept the subject under wraps, quickly buried the anomaly by inventing a new disease called ICL (Idiopathic CD4+Lympho-cytopenia)—a conveniently forgettable name that means "AIDS without HIV."

There are probably thousands of cases of AIDS without HIV in the United States alone. Peter Duesberg found 4,621 cases recorded in the literature, 1,691 of them in this country. (Such cases tend to disappear from the official statistics because, once it's clear that HIV is absent, the CDC no longer counts them as AIDS.) In a 1993 article published in Bio/Technology, Duesberg documented the consistent failure of the CDC to report on the true incidence of positive HIV tests in AIDS cases. The CDC concedes that at least 40,000 "AIDS cases" were diagnosed on the basis of presumptive criteria-that is, without antibody testing, on

the basis of diseases such as Kaposi's sarcoma. Yet these diseases can occur without HIV or immune deficiency. Perhaps some of the patients diagnosed as having AIDS would have tested negative, or actually did test negative, for HIV. Physicians and health departments have an incentive to diagnose patients with AIDS symptoms as AIDS cases whenever they can, because the federal government pays the medical expenses of AIDS patients under the Ryan White Act but not of persons equally sick with the same diseases who test negative for HIV antibodies.

The claimed correlation between HIV and AIDS is flawed at an even more fundamental level, however. Even if the "AIDS test" were administered in every case, the tests are unreliable. Authoritative papers in both *Bio/Technology* (June 1993) and the *Journal of the American Medical Association* (November 27, 1991) have shown that the tests are not standardized and give many "false positives" because they react to substances other than HIV antibodies. Even if that were not the case, the tests at best confirm the presence of antibodies and not the virus itself, much less the virus in an active, replicating state. Antibodies typically mean that the body has fought off a viral infection, and they may persist long after the virus itself has disappeared from the body. Since it is often difficult to find live virus even in the bodies of patients who are dying of AIDS, Gallo and others have to speculate that HIV can cause AIDS even when it is no longer present and only antibodies are left.

Just as there are cases of AIDS without HIV, there are cases of HIV-positive persons who remain healthy for more than a decade and who may never suffer from AIDS. According to Greene's article in *Scientific American*, "It is even possible that some rare strains [of HIV] are benign. Some homosexual men in the U.S. who have been infected with HIV for at least 11 years show as yet no signs of damage to their immune systems. My colleagues . . .and I are studying these long-term survivors to ascertain whether something unusual about their immune systems explains their response or whether they carry a virulent strain of the virus."

The faulty correlation between HIV and AIDS would not disprove the HIV theory if there were strong independent evidence that HIV causes AIDS. As we have seen, however, researchers have been unable to establish a mechanism of causation. Nor have they succeeded in confirming the HIV model by inducing AIDS in animals. Chimps have repeatedly been infected with HIV, but none of them have developed AIDS. In the absence of a mechanism or an animal model, the HIV theory is based only upon a correlation that turns out to be primarily an artifact of the theory itself. In light of the importance of the correlation argument, it is astonishing that no controlled studies have been done for three of the major risk groups: transfusion recipients, hemophiliacs, and drug abusers. Two ostensibly controlled studies involving men's groups in Vancouver and San Francisco purportedly show that AIDS developed only in the HIV-positive men and never in the "control group" of HIV negatives. These studies were designed not to test the HIV theory but to measure the rate at which HIV-positive gay men develop AIDS. They did not compare otherwise similar persons who differ only in HIV status, did not control effectively for drug use, and did not fully report the incidence of AIDS-defining diseases in the HIV-negative men. The research establishment accepted these studies uncritically because they give the HIV theory some badly needed support. But the main point they supposedly prove has already been thoroughly disproved: AIDS does occur in HIV-negative persons.

According to the official theory, HIV is a virus newly

introduced into the American population, which has had no opportunity to develop any immunity. It follows that viral infection should spread rapidly, moving from the original risk groups (gays, drug addicts, transfusion recipients) into the general population. This is what the government agencies confidently predicted, and AIDS advertising to this day emphasizes the theme that "everyone is at risk."

The facts are otherwise. AIDS is still confined mainly to the original risk groups, and AIDS patients in the United States are still almost 90-percent male. Health-care workers, who are constantly exposed to blood and bodily fluids of AIDS patients, have no greater risk of contracting AIDS that the population at large. Among millions of health- care workers, the CDC claims only seven or eight (poorly documented) cases of AIDS supposedly developed through occupational exposure. By contrast, the CDC estimates that accidental needle sticks lead to more than 1,500 cases of hepatitis infection each year. Even prostitutes are not at risk for AIDS unless they also use drugs.

Far from threatening the general heterosexual population, AIDS is confined mainly to drug users and gay men in specific urban neighborhoods. According to a 1992 report by the prestigious U.S. National Research Council, "The convergence of evidence shows that the HIV/AIDS epidemic is settling into spatially and socially isolated groups and possibly becoming endemic within them." This factual picture is so different from what the theory predicts, and so threatening to funding, that the AIDS agencies have virtually ignored the National Research Council report and have continued to preach the fiction that "AIDS does not discriminate."

Not only is AIDS mostly confined to isolated groups in a few U.S. cities, but HIV infection is not increasing. Although a virus newly introduced to a susceptible population should spread rapidly, for several years the CDC has estimated that a steady 1 million Americans are HIV positive. Now it appears that the figure of 1 million is finally about to be revised-downward. According to a story by Lawrence Altman in the March 1 New York Times, new statistical studies indicate that only about 700,000 Americans are HIV positive, and the official estimate will accordingly be reduced sometime this summer.

While HIV infection remains steady at this modest level in the United States, World Health Organization officials claim that the same virus is spreading rapidly in Africa and Asia, creating a vast "pandemic" that threatens to infect at least 40 million people by the year 2000, unless billions of dollars are provided for prevention to the organizations sounding the alarm. These worldwide figures, especially from Africa, are used to maintain the thesis that "everyone is at risk" in the United States. Instead of telling Americans that AIDS cases here are almost 90-percent male, authorities say that worldwide the majority of AIDS sufferers are female. With the predictions of a mass epidemic in America and Europe failing so dramatically, AIDS organizations rely on the African figures to vindicate their theory.

But these African figures are extremely soft, based almost entirely on "clinical diagnoses," without even inaccurate HIV testing. What this means in practice is that Africans who die of diseases that have long been common there—especially wasting disease accompanied by diarrhea-are now classified as AIDS victims. Statistics on "African AIDS" are thus extremely manipulable, and witnesses are emerging who say that the epidemic is greatly exaggerated, if it exists at all.

In October 1993, the *Sunday Times* of London reported on interviews with Philippe and Evelyne Krynen, heads of a 230-employee medical relief organization in the Kagera province of Tanzania. The Krynens had first reported on African AIDS in 1989 and at that time were convinced that Kagera in particular was in the grip of a vast epidemic. Subsequent years of medical work in Kagera have changed their minds. They have learned that what they had thought were "AIDS orphans" were merely children left with relatives by parents who had moved away and that HIV-positive and HIV-negative villagers suffer from the same diseases and respond equally well to treatment. Philippe Krynen's verdict: "There is no AIDS. It is something that has been invented. There are no epidemiological grounds for it; it doesn't exist for us."

Krynen's remark calls attention to the fact that AIDS is not a disease. Rather, it is a syndrome defined by the presence of any of 30 separate and previously known diseases, accompanied by the actual or suspected presence of HIV. The definition has changed over time and is different for Africa (where HIV testing is rare) than for Europe and North America. The official CDC definition of AIDS in the United States was enormously broadened for 1993 in order to distribute more federal AIDS money to sick people, especially women with cervical cancer. As a direct result, AIDS cases more than doubled in 1993. Absent the HIV mystique, there would be no reason to believe that a single factor is causing cervical cancer in women, Kaposi's sarcoma in gay males, and slim disease in Africans.

The HIV paradigm is failing every scientific test. Research based upon it has failed to provide not only a cure or vaccine but even a theoretical explanation for the disease-causing mechanism. Such success as medical science has had with AIDS has come not from the futile attempts to attack HIV with toxic antiviral drugs like AZT but from treating the various AIDS-associated diseases separately. Predictions based on the HIV theory have been falsified or are supported only by dubious statistics based mainly on the theory itself. Yet the HIV establishment continues to insist that nothing is wrong and to use its power to exclude dissenting voices, however eminent in science, from the debate.

Like other leaders of the scientific establishment, *Nature* Editor John Maddox is fiercely protective of the HIV theory. He indignantly rejected a scientific paper making the same points as this article. When Duesberg first argued his case in 1989 in the prestigious *Proceedings of the National Academy of Science*, the editor promised that his paper would be answered by an article defending the orthodox viewpoint. The response never came. The editors of the leading scientific journals have refused to print even the brief statement of the Group for the Scientific Reappraisal of the HIV/AIDS Hypothesis, which has over 300 members. The statement notes simply that "many biomedical scientists now question this hypothesis" and calls for "a thorough reappraisal of the existing evidence for and against this hypothesis."

Such a reappraisal would include the following elements: (a) *Genuinely controlled epidemiological studies of all the major risk groups:homosexuals, drug users, transfusion recipients, and hemophiliacs.* The studies should employ an unbiased definition of AIDS. Too often we have been told that HIV always accompanies AIDS, only to learn that this is so because AIDS without HIV is named something else. The studies should be performed by persons who are committed to investigating the HIV theory rather than defending it. There is reason to suspect that properly controlled studies of transfusion recipients and hemophiliacs in particular will

show that the incidence of AIDS-defining diseases is independent of HIV status.

(b) *An audit of the CDC statistics to remove HIV bias and thereby allow unprejudiced testing of the critical epidemiological evidence for the theory.* Every effort should be made to determine how many AIDS patients were actually tested for antibodies and the testing method that was employed. Because even the most reliable antibody test generates many false-positive results, researchers should try to validate the tests by examining random samples of AIDS patients to determine whether significant amounts of replicating HIV can be found in their bodies. Statistics have been kept as if the purpose were to protect the HIV theory rather than to learn the truth.

(c) *Research focusing on the cause of particular diseases rather than the politically defined hodgepodge of diseases we now call AIDS.* The cancer-like skin disease called Kaposi's sarcoma (KS) is one of the best-known AIDS-defining conditions, but leading KS and HIV experts Marcus Conant and Robin Weiss now say that dozens of non-HIV KS cases are under study in the United States and that KS is becoming much less frequent in gay male AIDS patients than it formerly was. Conant, Weiss, and other AIDS researchers now frankly attribute KS to an "unknown infectious agent" rather than to HIV, but KS is nonetheless still called AIDS when it occurs in combination with HIV. Duesberg attributes KS in gay males to the use of amyl nitrates (poppers) as a sexual stimulant. Another example: Hemophiliacs in the age of AIDS are living longer than they ever did in the past, but they still often die of conditions related to receipt of the blood concentrate called Factor VIII. Research published in The Lancet in February confirms earlier reports that symptoms diagnosed as AIDS are best treated by providing a highly purified form of Factor VIII. Researchers should study the role of blood-product impurities in causing disease in hemophiliacs, without the distortion that comes from arbitrarily assuming that HIV is responsible whenever an HIV-positive hemophiliac becomes ill.

(d) *A critical re-examination of the statistics for AIDS and HIV in Africa and Asia.* Researchers should perform new, controlled studies of representative African populations to test the relationship of confirmed HIV infection to the incidence of AIDS-defining diseases. It will not do to rely upon "presumptive diagnoses" or extrapolations from single antibody tests that are now well known to generate many false positives.

The HIV establishment and its journalist allies have replied to various specific criticisms of the HIV theory without taking them seriously. They have never provided an authoritative paper that undertakes to prove that HIV really is the cause of AIDS-meaning a paper that does not start by assuming the point at issue. The HIV theory was established as fact by Robert Gallo's official press conference in 1984, before any papers were published in American journals. Thereafter, the research agenda was set in concrete, and skeptics were treated as enemies to be ignored or punished. After 10 years of failure, it is time to take a second look.

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AIDS IN AFRICA?

Eleni Papadopulos-Eleopulos & Valendar Turner

Rethinking AIDS Jan. 1995

According to the World Health Organization, some 2.5 million Sub-Saharan Africans have AIDS-Africa is apparently in the grip of an AIDS pandemic. (In the USA 300,000 people have been listed as AIDS cases.) AIDS in Africa is portrayed as providing two important lessons for the West. The first is an example of the potential devastation that AIDS can unleash; the second is that by heterosexual spread, AIDS will eventually overtake the West. However, there is no convincing evidence that millions of Africans are infected with HIV, the putative cause of AIDS, or that African AIDS is heterosexually spread.

The only evidence that some Africans are "infected" with a virus called HIV is indirect, being based on the random testing of Africans' blood for the presence of antibodies that react with a collection of so-called HIV proteins. If the "HIV proteins" (present in the test kits) only reacted with HIV antibodies there would be no problem. Unfortunately, this is not the case. Antibodies produced in response to the presence of one foreign agent may also react with another different foreign agent; and the more infectious agents that a person has been exposed to, the greater is the likelihood that such cross-reacting antibodies will be present. Ruling out cross-reactions between "HIV proteins" and the plethora of other antibodies present in individuals who are constantly exposed to microbial agents, can only be achieved by determining how good a match there is between the antibody reactions and presence or absence of pure HIV itself. In other words, an isolated viral preparation of known purity must be used as a "gold standard" for the antibody reactions. This has never been done, either in Africa or in the West. Thus in Africa, no one knows whether the antibody tests are specific for HIV, that is, whether a positive test actually means HIV infection. Many experts on African AIDS accepted this fact even at the beginning of the AIDS era. Earlier this year, Myron Essex, a leading American researcher and his colleagues from Harvard University, when discussing their experimental data on HIV antibody testing in Africa, again warned that the HIV antibody tests "may not be sufficient for HIV diagnosis in AIDS-endemic areas of Central Africa where the prevalence of mycobacterial diseases [leprosy and tuberculosis and others, whose antibodies cross-react] is quite high". Thus, in Africa there is no certainty that Africans are actually infected with a putative new agent, HIV. AIDS experts also agree that acquired immune deficiency (the "AID" in AIDS) is also long standing in Africa. Immune deficiency can be caused by malnutrition, certain viral infections, and diseases such as malaria and tuberculosis, all of which are known to exert a major depressant action on the immune system.

Unlike the West, AIDS in Africa is diagnosed without any laboratory tests. Patients are classified as AIDS cases without laboratory proof that they have either immuno deficiency or HIV infection. All that is required is to have various clinical conditions. But the conditions accepted as forming the "S"(syndrome) of "AIDS" in Africa bear no relationship to AIDS in the West. In the West, AIDS is diagnosed if a person has one or more of approximately 27 relatively rare diseases.

However in Africa, AIDS is diagnosed according to the World Health Organization's 1986/87 Bangui' definitions that can best be described as a collage of common non-

specific symptoms, such as cough, fever, diarrhea, tuberculosis (TB) and a cancer called Kaposi's sarcoma. Every one of these diseases have been endemic in Africa for generations.

Kaposi's sarcoma, for example, was described in the Ebers papyrus dating from 1600 BC. (In the West, Kaposi's sarcoma is restricted to gay men.) Of the 661 million people in sub-Saharan Africa, 2-3 million have active TB with an annual mortality of 790,000. Despite this and the fact that in adults, "HIV infection" usually follows TB infection, TB has now become an AIDS defining illness. In fact, 30-50% of African "AIDS" deaths are from TB. In spite of all this, AIDS experts expect that we should accept that something "new" is afoot in Africa and that it is caused by a new agent, HIV. Suddenly, a new disease, caused by a new agent has appeared. The old diseases and their deleterious effects on the immune system are no longer operative.

Many AIDS experts also expect us to believe that unlike the story in the West, in Africa AIDS is spread predominantly by heterosexual contact. Indeed, since the number of heterosexual cases in the West is too small to be statistically meaningful, the African "evidence" is used to forecast the same predicament in the West. The claim of heterosexual spread in Africa is based on absence of "evidence of homosexual transmission or intravenous drugs" and the approximately equal numbers of males and females who have AIDS as well as positive antibody tests. The latter certainly does not prove that AIDS is heterosexually spread-influenza and appendicitis also have an equal sex distribution.

Given the fact that positive HIV antibody tests may be due to the presence of antibodies formed in response to malaria, tuberculosis, leprosy and many parasitic diseases it is not surprising that an equal number of men and women will be diagnosed as "AIDS" according to centuries-old symptoms and have a positive antibody test.

In any case, the theory that AIDS in Africa is transmitted heterosexually creates more problems for the HIV theory of AIDS than it solves. A disease is said to be caused by a sexually transmitted infectious agent if one infected partner, say the active partner (man) transmits the agent/disease to the passive partner (woman), who in turn transmits the agent/disease to another man. That is, heterosexually transmitted diseases are transmitted bidirectionally, from men to women to men. In the West, the largest (thousands of cases) and most judiciously conducted prospective epidemiological studies have proven beyond all reasonable doubt that in both men and women the only sexual act leading to the acquisition of "HIV antibodies"(women) or "HIV antibodies" and eventual AIDS (gay men) is passive (receptive) anal intercourse. In other words, in the West, "HIV antibodies" and AIDS, like pregnancy, can only be acquired by the passive partner. If, unlike pregnancy, the "HIV antibodies" and AIDS are not caused by a non-infectious agent (sperm, semen) but by HIV, then HIV will be the only unidirectionally sexually transmitted infectious agent. The active partner will have to acquire HIV by other means. This is strange enough: in the whole history of Medicine there has never been a sexually transmitted agent/disease which is spread unidirectionally in the West and bidirectionally (heterosexually) in Africa.

The only other alternative to this ludicrous scenario is to agree with African physicians that positive HIV antibody tests in Africa do NOT mean infection with HIV and that immunosuppression and certain symptoms and diseases which constitute African AIDS have existed in Africa since

time immemorial. According to Professor P.A.K. Addy, Head of Clinical Microbiology at the University of Science and Technology in Kumasi, Ghana:
"Europeans and Americans came to Africa with prejudiced minds, so they are seeing what they wanted to see...I've known for a long time that AIDS is not a crisis in Africa as the world is being made to understand. But in Africa it is very difficult to stick your neck out and say certain things. The West came out with those frightening statistics on AIDS in Africa because it was unaware of certain social and clinical conditions. In most of Africa, infectious diseases, particularly parasitic infections, are common. And there are other conditions that can easily compromise or affect one's immune system."

Dr. Konotey-Ahulu from the Cromwell Hospital in London expresses a similar view: "Today, because of AIDS, it seems that Africans are not allowed to die from these conditions [from which they used to die before the AIDS era] any longer. If tens of thousands are dying from AIDS (and Africans do not cremate their dead) where are the graves?" According to him, the uppermost question in the minds of intelligent Africans and Europeans in that continent is: "Why do the world's media appear to have conspired with some scientists to become so gratuitously extravagant with the untruth?"

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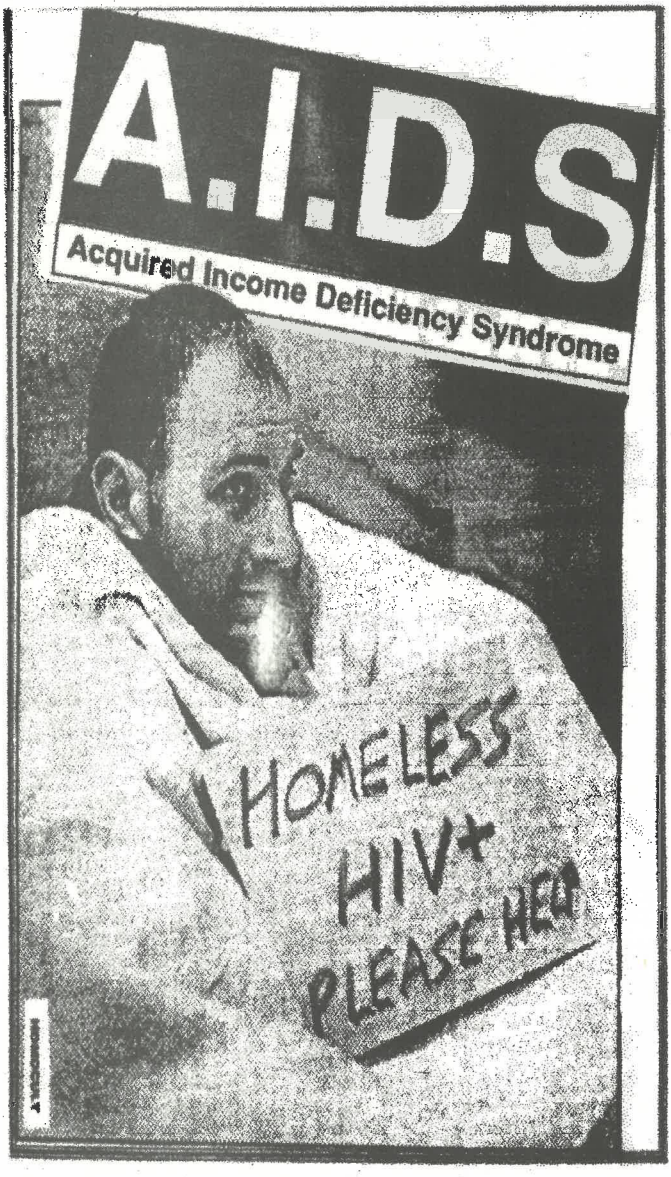


A POSSIBLE SOLUTION AT LAST

Prof. Peter Duesburg.

Questioning AIDS, 1996.

It is concluded that the HIV hypothesis has been unproductive and nonpredictive because AIDS is neither an infectious epidemic nor caused by HIV. Thus, far from solving AIDS, the HIV hypothesis has actually escalated the epidemic by monopolizing AIDS reasearch and therapy, and by delivering harmful medications. As the theoretical basis of all anti-AIDS treatments the HIV hypothesis is solely responsible for over 1 million year-long prescriptions of AZT and all other toxic antiviral drugs that have never cured an AIDS patient. On the contrary, AZT and other anti-HIV/AIDS drug have been shown to accelerate death.

The HIV hypothesis is also responsible for the promotion of recreational drug use. By ignoring, obscuring and even directly refuting in the professional literature, the possibility that nitrites, cocaine and heroin could cause diseases, the medical orthodoxy misinforms a vulnerable and trusting public about the medical consequences of recreational drug use. The long arm of the international AIDS establishment even reaches out specifically to the public with targeted press releases to convince everybody that drugs are harmless as long as they are taken with clean needles and condoms to protect against HIV infection. This misinformation campaign and the campaign that clean needles for unsterile street drugs (!) and condoms protect against all medical consequences of drug use encourage rather than discourage recreational drug use by the unsuspecting public.

By contrast, our independent analysis of the AIDS epidemic reveals that AIDS is simply the clinical consequence of the American/European drug epidemic. The drug hypothesis resolves all long-standing paradoxes and contradictions of the HIV-hypothesis and predicts AIDS exactly, the hallmark of a good hypothesis. Therefore, it should have a very high priority in AIDS research. Drug toxicity could be tested experimentally in animals, and in human cells in tissue culture. In addition, drug toxicity could be tested epidemiologically in humans who are addicted to recreational drugs or are prescribed AZT. Such tests could be conducted at a microscopic fraction of the cost that is now invested in the HIV hypothesis.

According to the drug hypothesis AIDS would be entirely preventable and at least partially curable, if:
1) AZT and all other anti-HIV drugs were banned,
2) illicit recreational drug use was terminated,
3) AIDS patients were treated for their specific diseases with proved medications, e.g. tuberculosis with antibiotics, Kaposi's sarcoma with conventional cancer therapy, and weight loss with good nutrition.

In addition to saving about 50,000 to 75,000 lives per year from AIDS, the drug hypothesis could save the American tax payer up to $23 billion annually. Eight of the $23 billion are spent on AIDS treatment, research and education based on the unproductive HIV hypotheasis, and $15 billion are spent on the War on Drugs. The War on Drugs is "primarily focused on supply control efforts", but has failed completely to stop the American drug epidemic.

But if the wars on AIDS and drugs were based on the health consequences of long-term drug use, they could be just as successful as the federal anti-smoking program. Based on education that smoking causes lung cancer, emphysema and heart disease, smoking has dropped in the US from

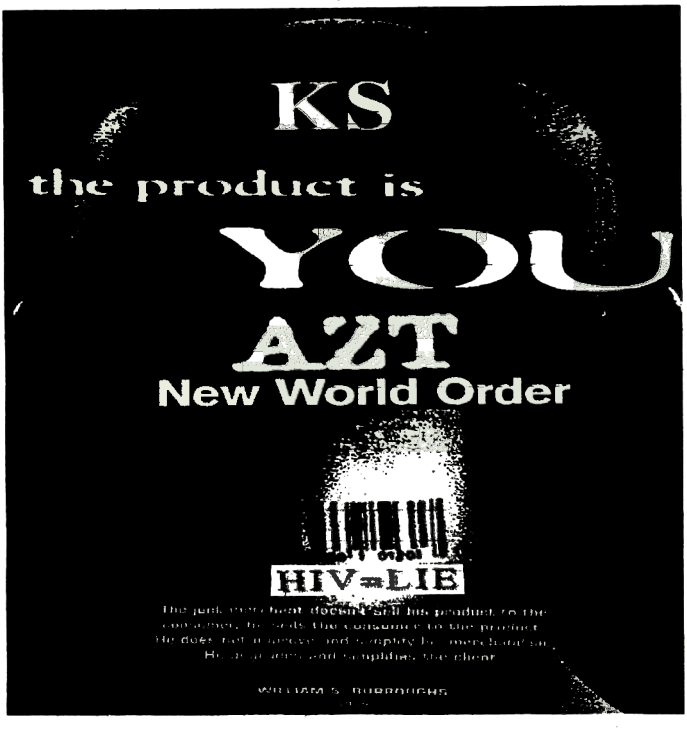
42% of the adult population in 1965 to 25% in 1995. And only 15.5% of Californians smoked regularly in 1995, down from 26% in 1984. In view of this the CDC's director of the Office of Smoking and Health proudly announced, "Not only are these states [California and others] doing something right, but other states are looking at them and seeing that this works". Thus by adopting the drug-AIDS hypothesis the CDC could also win the war on AIDS.

However, there are a number of monumental obstacles, 15 years in the making, that block the possible solution of AIDS based on the drug hypothesis:
1) The HIV/AIDS orthodoxy's annual budget of $8 billion from the US taxpayer alone,
2) The thousands of AIDS organizations, including countless public health and activist careers and the tens of thousands of scientific reputations that are exclusively built on HIV
3) The numerous medical and social benefits available to HIV-positive activists and patients
4) The staggering commercial interests in HIV-tests, over 20 million tests per year at $ 50 or more in the US alone, HIV-vaccines and anti-HIV drugs,
5) The prospects of numerous complaints and malpratice suits against the HIV/AIDS orthodoxy from those who were told they are destined to die based on HIV tests or were helped to die with AZT,
6) The prospect of a profound loss of confidence of the American public in its medical and scientific elite.

Thus the current HIV/AIDS orthodoxy cannot afford the drug hypothesis, and must do everything in its power to keep it from being presented to the American people. Likewise, the $15 billion federal establishment that conducts the War on Drugs would risk its large budget and thousands of career positions if the War on Drugs were won in the name of the hypothesis that drugs cause AIDS.

In sum, the drug hypothesis is testable and predicts that AIDS is entirely preventable and treatable by controling drug use. The solution of AIDS and significant progress in the War on Drugs are as close as a very testable and affordable non-HIV/AIDS hypothesis.

Peter Duesburg is a leading virologist at the University of California and one of the pioneers in the study of retroviruses. He is also perhaps the forerunner of HIV dissidence and has written several books on the subject.



LONG-TERM SURVIVAL

By Michael Callen

Talk Symposium Amsterdam 1992

I want to make one thing clear about what I'm going to say about long-term survivors: I'm not a scientist, I do not represent these to be scientific. You might think of me as the Monet of AIDS: I will give you impressions. I think they are worth something, but for those of you blue-suited people who want to see the data, all I have to offer is what I learned from actual long-term survivors, and I basically asked them in their own words why they thought they had survived and I covered a broad range of possible reasons and some patterns emerged.

Long term survival: first thing to say is that we exist. You might not know it if you relied for your information on mainstream media. According to the US government statistics - which you can believe or not, they are not very well kept, but they are all we have - at least in the US 9% of people with full blown AIDS live 3 years or more, and 5% live 5 years or more. Unfortunately, there have not been significent improvements in median survival since I was diagnosed in 1982. The life expectancy of a person with AIDS has only been extended by 6 months. I personally believe that that 6 months is attributable to our ability to prevent pneumocystis pneumonia, the number one killer of people with AIDS.

The first thing I want to say about long-term survivors is that there definitely is a survivor personality. But for every pattern I found, I found exceptions. And that actually made me very happy, because it says to me that there is no single way, there is no recipe, no magic way to become a long-term survivor. I personally believe that each person's AIDS is unique, is different. They probably arrived in it in a slightly different way. We are each bio-chemicaly, biologically, gentically unique. And so I never expected that any one approach would work for everybody with AIDS. But I do found the patterns that I found fascinating and I will provide them to you.

If I had to summarize in one word the common characteristic among survivors, it would be 'grit': people are incredibly feisty, incredibly knowledgable, not at all passive, very aggressively involved in the struggle to survive.

They spoke very passionately of what they referred to as 'healing partnerships with their health-care providers', by which they meant that they respected the opinions and expertise of the various health-care providers that they sought out, but they did not do something simply because they were told to do something. In every instance, they wanted to know what their options were, they wanted to know what the possible side-effects were, and they had worked out relationships with their health-care providers that permitted a dialogue to go back and forth. And in fact, one's relationship with one's doctor is probably the most important relationship that you have, with the possible exception of your lover, when you have AIDS. And it is a lot like having a lover: it involves fighting, and being honest about your emotions, and talking. And the long-term survivors that I interviewed were very eloquent about how they had worked over years to achieve a really open wonderful relationship with their health-care providers.

Every long-term survivor mentioned the phrase 'major life-style changes'. That meant the obvious: it meant that they immediately started practicing safe-sex, to avoid exposure

to other possible co-infectious factors. Most of them gave up drugs and alcohol, although some of them not entirely. Also, among lifestyle changes: a lot of people had dabbled with diet changes, but in almost no instance had anyone been able to persist in a radical diet change.

Everybody talked about, among lifestyle changes, what they called 'emotional house cleaning', usually after they had survived their first major opportunistic infection. It represented a crisis to them, and they did some soul searching. They went through their relationships and they either repaired them or they ended them. They spoke generally about needing to get rid of people in their lives who refused to support them in their belief that they could survive well beyond statistical projections.

I don't know whether it's true here, but in America Elizabeth Kubler-Ross is very popular and everybody is an instant expert on dying. And there are five stages, and people will constantly treat you as if you are in one of the stages, usually denial. If you talk about maybe sticking around longer than the 18 months allotted to you. People will look at you and say 'yeah, sure !' But long-term survivors were militant about it; they simply wouldn't put up with it. They spoke very movingly about needing to surround themselves with people who would support them in their hope.

Interestingly, another thing that everyone mentioned was that knowledge of another long-term survivor was crucial to maintaining their own belief in long-term survival. And that's really not so mysterious, when you stop to think about it. If you set out to do something that no human has ever done, it's a different experience than if you set out to do something that few humans have done. You know that it can be done.

The most surprising finding among my sample of long-term survivors was a clear rebirth of spiritualliity. With two exceptions - me and one other guy - all the long-term survivors talked about taking great comfort from their spiritual beliefs. It split almost in half: half had actually returned to the religions of their childhood, although none in a fundamentalist, judgemental way, and the other half spoke more generally of the sense that there was a meaning to suffering, a life after death. And there was no question that they took great comfort from those beliefs.

The long-term survivors were all passionately committed to life. That may sound pretty obvious, but for those of you who may have been around people with AIDS, this is going to sound simplistic, but I can't think of any other way to put it. When a catastrophic illness lands in your lap, you really have two choices: it's either a challenge to live, or challenge to begin dying, and I have seen people make both choices. I have seen people give up, die on cue, and I have seen people fight.

I want to be really clear here: there is, among people with AIDS, this short-hand notion, that if you want to be in the long-term survivor sweepstakes, you have to have the right attitude. But nobody ever really defines what that means. What is the right attitude? What I concluded from interviewing four dozen long-term survivors, as friends, is that you have to have the right attitude, by which I mean you have to believe in the possibility of survival, and you have to be hopeful and surround yourself with people who love and will support you. That will not, however, guarantee that you are a long-term survivor. The inverse seems to be true, however: I have not yet met a single person, who became a long-term survivor, who did not believe that it was possible.

It is interesting that, at least it was interesting to me, that the profile of extraordinary survivors with AIDS was pretty identical to the profile of extraordinary survivors of other so-called terminal diseases. Interestingly enough, about half of the long-term survivors were in long-term loving relationships, and those who were spoke about how they could not envision going through AIDS alone. And taking tremendous comfort and support from their loved-ones, and in some cases it was practical support.

All of the long-term survivors had dabbled with non-allopathic medicine. What I would say about the long-term survivors is that most integrated allopathic and non-allopathic medicine. Out of the 48 people I interviewed intensively, only one survivor had completely turned his back on Western medicine, and refused to take any pharmaceutical. And I have to say that he is still alive and glows with health. He is probably the healthiest among us. He is macrobiotic. Certainly, no single alternative approach to healing predominated, I mean, there were people who were into Reiki, or massage, or meditation, or diet, or vitamins. And frankly, most people did not stick with any one approach. There was a lot of walking around.

Virtually every long-term survivor was involved in the political struggle to end AIDS, which is very interesting to me. My theory of why that might be so is that AIDS can very easily consume you - your AIDS. You can close the world around you. When you have AIDS, to know that you are having some effect on other people, some beneficial effect on other people, to get outside your own tragedy and connect with other people, seem to be very important, seem to be healing.

I have been pretty prominent in my opposition to the use of AZT. And I didn't expect to find similar opposition among the long-term survivors, but I did. It was pleasantly surprising. Of the four dozen, only four had ever used it at all, and three are dead and one is dying of AZT-induced lymphoma. The overwhelming majority of long-term survivors had somehow managed to resist the enormous pressure to take AZT. This was very much a distinguishing characteristic of long-term survivors, by which I mean a scepticism about experimental medications. Long-term survivors, for what it's worth, take a very sceptical wait-and-see approach.

Nine out of 10 drugs that ever enter any phase of human testing fail, as either too toxic or non-effective. Well, that to me is quite startling if true: if the odds are stacked against you 9 to 1, then I do not understand the current drugs-into-body frenzy. My AIDS activist friends who are in the forefront of this drugs into-body frenzy, I feel are very misleading to people with AIDS who are frightened and desperate. They only seem to talk about two possible outcomes to taking experimental drugs: one is that it works and one that it doesn't. There is a third, apparently much more common possibility, which is that you will be worse off than if you did nothing at all. And nobody likes to talk about that because it's so unpleasant, but from my reading of the literature, sometimes doing nothing is much better than doing the wrong thing. And it would seem, on the record of government sponsored clinical trials, that most people are actually worse off taking these toxic drugs that if they hadn't started at all.

The above was abstracted from a transcript of a talk Michael Callen gave in May 1992 in Amsterdamat the international symposium 'AIDS; A Different View'.

Michael Callen is the author of 'Surviving AIDS' published by Harper Collins Publishers, New York1990, (ISBN 0-06-016148-5)

HIV VOODOO FROM BURROUGHS-WELLCOME

By John Lauritsen

New York Native 7 Jan. 1991

Those who have eyes to see are witnessing genocide-the genocide of gay men. Millions of dollars are now being spent on an international advertising campaign, "Living With HIV", in which gay men and other members of "risk groups" are being told: "Get tested for antibodies to HIV [the alleged "AIDS virus"] - if you "test positive" you need "medical intervention" which could "put time on your side" The "medical intervention" is AZT (also known as Retrovir and zidovudine), and the campaign is paid for, directly and indirectly, by Burroughs-Wellcome, the manufacturer of AZT.

The campaign consists of a phoney diagnosis followed by a lethal treatment. Already tens of thousands of objectively healthy gay men have been scared and bullied and bamboozled into taking AZT, allegedly in order to "slow the progression to AIDS". Optimism regarding their prognosis would be foolish. Except for the lucky few who stop "treatment" in time, they will die. Death is the expected biochemical consequence of taking AZT, for the fundamental action of the drug is to terminate DNA synthesis, the very life process itself. As Joseph Sonnabend has stated, "AZT is incompatible with life". Without a single benefit demonstrated by honest and competent research, AZT can do nothing but kill.(1)

It is odd, the power of words to cloud reality or discredit a line of reasoning. A British journalist once told me that no one would ever believe what I wrote if I persisted in using words like "genocide". My response is that, while I want my arguments to be convincing, I write what I consider to be true, not necessarily what people will find believable. Genocide has occurred at other times and in other places, and it is happening here and now, whether or not anyone wishes to believe it.

Craig Schoonmaker, the founder of Homosexuals Intransigent, has suggested the word "autogenocide", to emphasize the role of low self-esteem and self-hatred in motivating gay men to acquiesce in their own destruction. Casper Schmidt, a New York City psychiatrist, has proposed "pharmacogenocide"-genocide through drugs. The late Robert S. Mendelsohn put forward the word "iatrogenocide" in his best seller, Confessions of a Medical Heretic: A new word was recently coined by Dr. Quentin Young to describe one activity of Modern Medicine: iatrogenocide. Iatrogenocide (iatros in the greek for doctors) is the systematic destruction of a large group of people by doctors.(2)

This new form of genocide, directed against gay men, rests on two pillars: Homophobia and Profit. The ancient taboo from the Holiness Code of Leviticus, which prescribed the death penalty for males who had sex with each other, is now being carried out, profitably, by the pharmaceutical industry: "If a man lie with mankind as with a woman, both of them have committed an abomination: they shall surely be put to death; their blood shall be upon them." (Leviticus 20:13)

Jewish priests 2500 years ago ordained death by stoning for the "abomination" of sex between males. Modern priests, the doctors, prescribe AZT, and they do so with the extraordinarily hypocritical dogma that by giving a life-

terminating drug they are really "extending life". Considering the agonizing side effects of AZT "treatment", it might be argued that death by stoning were preferable.

Deadly Diagnosis + Lethal Treatment = Genocide

The weaknesses of the HIV-AIDS hypothesis have been discussed elsewhere.(3) Behind the scenes a growing number of important scientists are now convinced that HIV is not the cause of "AIDS". The two "discoverers" of HIV, Luc Montagnier of the Pasteur Institute and Robert Gallo of the National Cancer Institute, have both reneged on promises to defend the HIV-AIDS hypothesis against the criticisms of Peter Duesberg, and have therefore lost the debate by default.

What does it mean to be diagnosed as "HIV positive"? Objectively it means nothing, other than having antibodies to a harmless passenger virus. In the absence of "medical treatment" or other specific health risks, there is no reason why someone who is "HIV positive" should not live to a ripe old age.

The "HIV positive" diagnosis itself, however, can be deadly. It has led to suicides, has destroyed marriages and careers, and is used to justify AZT treatment. An East Berlin writer recently summed it up with the phrase, "Nicht das Virus, sondern die Diagnose totet". ("The virus doesn't kill, the diagnosis does.")(4)

The toxicities of AZT have also been described elsewhere.(5) The short-term (acute) toxicities of AZT are serious, and many patients die of them. These toxicities include severe anemia, muscle disease, and damage to the kidneys, liver, and nerves. However, it is the long-term (chronic) toxicities that are of most concern when AZT is being prescribed for healthy people to take for the rest of their lives. The cumulative, long-term effects of AZT are unknown, since no one has lived for more than three years on AZT treatment. However, the evidence we have-including biochemical analyses, test tube studies, rodent studies, and correlations between cancer of the lymph system and AZT therapy-strongly indicates that AZT will cause cancer in the long run.

So then, perfectly healthy members of a group, which is hated for theological reasons, are persuaded through lies to take a drug that will kill them. If there's a better word than "genocide" to describe this, I'd like to know what it is.

The Marketing of Genocide

Burroughs-Wellcome's full-page "Living With HIV" advertisements have appeared in The New York Times and in lesser publications all over the world. In a typical ad, a man is shown in silhouette by a grand piano, his head bowed in dejection, and above his head the statement, "I learned I was HIV positive 5 years ago. I felt angry, deserted, and victimized." At the bottom of the ad is an insert photograph of the same man, now smiling and confident: "Today I'm back in control." The theme of "control" is echoed in the ad slogan, "The sooner you take control the better." In all of the "Living With HIV" ads, the body copy is the same: Every day, more and more people are learning to live with HIV. People are finding ways to stay healthier, strengthen their immune systems, develop positive attitudes. They've found that proper diet, moderate exercise, even stress management can help. And now, early medical intervention could put time on your side. Today, HIV positive doesn't mean you have to give up. So, the sooner you take control, the better. For more information on living with HIV, we urge you to call the number below

...anonymously, if you wish.
Such phrases as "stay healthier" and "put time on your side" are insidious, as they suggest that someone with HIV antibodies is already sick and doomed. The references to diet, exercise, and so on are merely window dressing. Any HIV positive who calls the number will find out soon enough that "taking control" means "early medical intervention" means AZT.

In their nauseating hypocrisy, the Burroughs-Wellcome ads are reminiscent of a series of ads which in 1983 were run in gay publications for Great Lakes Products, the world's largest manufacturer of poppers (nitrite inhalants). Entitled "Blueprint for Health", the Great Lakes ads gave advice to gay men on how to stay healthy through exercise, nutrition, stress reduction, and so on. And this "message of good health and wellness" was sponsored by the manufacturer of poppers, a drug which, among other things, damages chromosomes; causes anemia, immune suppression, and cardio-vascular collapse; and forms carcinogenic compounds in the body.(6)

Concomitant with the Burroughs-Wellcome ads, The New York City Department of Health put up posters with the theme, "Living Longer, Staying Strong", conveying essentially the same message, that "people with HIV" are sick and doomed, but might "stay healthy longer" with the help of "early health care and new medicines".

Genocide doesn't take holidays. On Christmas day I was listening to WINS radio, and heard a "Message on HIV" from the Centers for Disease Control (CDC). It was a virtual clone of the "Living with HIV" series. I called the number, and the woman who answered gave me the now-familiar pitch about the importance of getting tested, early medical intervention, and the rest of it.

The Gay Press Promotes Autogenocide

Gay publications all over the world, from local bar rags to those with international circulations, are now carrying the "Living with HIV" ads. *The New York Native* and the west coast magazine *Outlook* are the only exceptions I know of. According to an article by Chris Bull in *The Advocate*, Burroughs-Wellcome marketing representative Joe DiSabato found "little opposition to the ads from the gay press." DiSabato richly deserves the 1990 gay Pollyanna prize for his statement, "In a way Burroughs Wellcome is giving money back to the community through the campaign. Economically, this will be great for the gay press."

The German magazine *Magnus* received 20,000 DM to run a Burroughs-Wellcome ad, and a prominent gay activist with "AIDS" was recruited to assist in the campaign. A Burroughs-Wellcome ad appeared in the latest issue of *Babilonia*, from Milan. In Houston, the Body Positive group received $85,000 plus donations of computers and other equipment from Burroughs-Wellcome. In return, *Body Positive* ran under its own name a series of television, radio, billboard, and press advertisements with the theme, "We can't get results until you do." For those who would test positive, the ads offered the bleak hope, "There's a chance for a longer and healthier life with early medical intervention." Houston's mayor, Kathy Whitmire, proclaimed September the "Get Tested Now" month, stating that, "prompt medical and psychological intervention can slow down the progress of the [HIV] disease and ameliorate some of its effects."

Some of the ads in the gay press were sponsored by branches of the Public Health Service, paid for with our tax

money. One such ad, which ran in Au Courant (Philadelphia), contained the following copy: Today, people with HIV are doing something most of us didn't think possible. Living longer. Today, a person who is infected with HIV and receives prompt treatment can live longer. If you are at risk [read: if you are gay], now's the time to seek counseling and testing. If you are infected with HIV, work with a doctor to understand medical options that may prolong your life.

The Psychology Of Genocide

In formulating hypotheses on what might be the real causes of "AIDS", multifactorialists who reject the HIV-AIDS hypothesis have concentrated on such probable etiological factors as "recreational" drug use, known and yet-to-be-identified infectious agents, and excessive medical treatment with antibiotics and other drugs. We have, regrettably, tended to slight psychological factors. This is unfortunate, as the concept of psychosomatic illness is well established. There can be no doubt that extreme and chronic fear, depression, stress, and grief are capable of causing illness and death.

In 1983 the Journal of Psychohistory published a paper by Casper Schmidt, which was perhaps the first to challenge the "AIDS virus" hypothesis.(7) Entitled "The Group-Fantasy Origins of AIDS", this brilliantly original essay advances the thesis that epidemic AIDS has a psychosocial origin-that AIDS is psychologically contagious, being spread through suggestion rather than through microbes. In Schmidt's view, we are witnessing a mass sacrificial ritual, with sadistic persecutors on one side and willing (masochistic) sacrificial victims on the other. The extraordinary irrationality that characterizes the AIDS epidemic can be explained through the concept of group fantasy-people are collectively in a trance.

Schmidt is somewhat more tentative in trying to explain why gay men and other members of "risk groups" are getting sick in ways that qualify for a diagnosis of "AIDS". He proposes that chronic and inescapable fear can elicit a biochemical reaction in the body, which in time causes "psychogenically-reduced cell-mediated immunity". He maintains that this hypothesis has fulfilled the animal model for "AIDS", inasmuch as laboratory animals subjected to inescapable threats have developed immune deficiency. While I withhold judgment on this aspect of Schmidt's thesis, I wholeheartedly agree that a sacrificial ritual is taking place. Especially noteworthy, in my opinion, is the role of the facilitators-those gay men (and lesbians) who are leading the victims to the sacrificial altar, without necessarily allowing themselves to be sacrificed.

In this second wave of sacrifices, in which perfectly healthy people are being targeted for genocide, a crucial role is played by psychological suggestion. Highly sophisticated psychological techniques are being used to make gay men perceive themselves as sick, and become sick, in order to qualify as consumers of AZT. The "Living With HIV" campaign is, quite literally, a form of voodoo.

Michael Ellner, the president of the Health Education AIDS Liaison (HEAL), recently posed the question of whether unrecognized hypnosis might not be a risk factor in the development of "AIDS". A certified master hypnotherapist himself, Ellner believes that classic elements of hypnosis are present in the "Living With HIV" campaign, in innumerable pronouncements from AIDS groups and public health agencies, and in a recent video from Burroughs-Wellcome (about which more below). Ellner cited the elements of hypnotism as being, in no particular order:

perceived authority, fixation, suggestion, repetition, confusion, relaxation, imagination and post-hypnotic suggestion. In a recent paper by Michael Ellner and Andrew Cort, "Programmed to Die: Cultural Hypnosis and AIDS", the following points are made: Bone pointing, or voodoo death, is a well-documented hypnotic phenomenon that clearly demonstrates the awesome power of belief. There are people in Africa, Haiti and Australia with the belief that the shaman (or witch doctor) has power over life and death. For them, being the target of a bone pointed by such an authority can be fatal. The hex is harmless to a non-believer; but to a believer it is deadly. After having a bone pointed at them, healthy people go home and obediently die.(8)

A Burroughs-Wellcome video: Brainwashing the Doctors

A few months ago, doctors who treat AIDS patients received a video cassette from Burroughs-Wellcome, "The Psychology of Treating Patients With HIV Disease". The basic premises of the video are the same as those of the "Living With HIV" campaign, that "HIV infection" and "AIDS" are more or less equivalent, and that early medical intervention (with AZT/Retrovir) is called for. Beyond this, doctors are told to "ally with the treatment", by knocking down any hesitation or objections their "HIV-infected" patients might have to going and staying on AZT therapy.

The video is narrated by Leon McKusick, Ph.D., a gay psychologist in San Francisco. In the beginning his voice is heard saying: HIV disease is coming to be seen as a chronic infection. And for many individuals this is the first intimate realization of death and disease, particularly among those who are relatively young. After McKusick introduces himself, he quickly gets to the point: The decisions surrounding the initiation of Retrovir therapy force you, the physician, to evaluate the patient's support network.... This video will share with you the psychological reactions we've seen from patients who are diagnosed positive for the HIV antibodies, and then alert you to the emotions that follow as they encounter the progression of the disease and then are motivated towards treatment with Retrovir.

McKusick describes "HIV-related depression", emphasizing that the symptoms mimic those of HIV infection itself, as well as "some of the early side effects of AZT". In other words, if a patient on AZT should experience sleep disturbance, eating problems, fatigue, or weight loss, these might be merely short-term "HIV-related depression", rather than side effects of AZT. For physicians to "assist individuals going through emotional depression reacting to HIV or going on treatment", McKusick offers the following guidelines: enlightened reassurance, cognitive reframing, social support, reinforce structure, plan of action. In commenting on the video, Michael Ellner has expressed the opinion that "cognitive reframing" means hypnotizing or brainwashing the patient.

The video features a panel discussion, with two doctors and a number of people with AIDS (PWAs). Like McKusick, the other two authority figures are gay and are identified with title: Marcus Conant, M. D., and Ron Grossman, M. D., whereas the PWAs are identified simply as "Bob", "Steve", "Tom", and "Bill". Drs. McKusick, Conant and Grossman are understanding facilitators. Bob, Steve, Tom, and Bill are willing victims.

Grossman argues that "AIDS" ought to renamed as "HIV spectrum". His words are regarded by his colleagues as profound and original. McKusick says, "Sometimes it's best to combat feelings of stigmatization with a sense of humor."

He smiles. The camera shifts to Conant, who tries to smile-but his face is heavy and his eyes are dead tired. And then Bob tells an anecdote. It seems he was in a play writing workshop when the timer of his AZT pill box went off: Twenty pairs of eyes zeroed in on me. The only thing I could do, I took out the pill box and turned it off-and they were still looking-so obviously I had to respond to it-so I made a joke out of it. I said, "It's a phenomenon of the latter part of the 20th century in the United States. Every four hours, gay men start to beep." Bob stops speaking. It becomes apparent that the point of his joke has been made, and that people are expected to laugh. They begin laughing. The camera goes from one person to another to show them laughing. They applaud Bob's performance. Clearly Bob is intended to be a role model. He states, "As soon as I started taking action, I started feeling better.... Action is the key to salvation."

The prickly topic of AZT's side effects is raised. McKusick asserts that the physicians role ought to be "helping the patient realize that their fears were unfounded." Robert makes a joke about "horror stories" of side effects. Everyone laughs. McKusick then declares that anxiety symptoms are very much like both HIV symptoms and early symptoms of AZT side effects. He artfully sows confusion by stating: "Sometimes a person could benefit medically from the drug, but could reject the drug for psychological reasons. Some patients, who have just begun AZT, have complained about side effects which, once they've talked about it with their counsellors, were determined to be more related to their anxiety about being on the drug, than to the drug itself.... Sometimes a person could benefit medically from the treatment, but rejects the drug for psychological reasons, after being on it for just a brief period. Therefore, it's important to recognize that some of your patients' early reactions may be psychological."

Bob makes his contribution: "I have to say-Thank God! — that I have had no side effects whatsoever." Bob clearly is not well. His skin is stretched taut over a death's head, and his facial expressiveness is limited to rolling his eyes. He mentions a few symptoms, which he attributes to HIV, and says, "I can handle that". He laughs bravely. McKusick commends Bob on the way he "handles attribution". It's very important", says McKusick, "to ally with the drug against the disease." The single most stomach-turning episode in the video is provided by the New York physician, Ron Grossman, who smiles as he delivers the following little speech: "That pill should be an absolute symbol of life, and not a symbol of "Oh, I've got this...." (Marcus Conant nods in agreement) The whole issue of empowerment here, of people taking charge of their own lives, is involved with this decision making, to take this drug."

To summarize: The whole thrust of the video is to downplay AZT's side effects. Doctors are to dismiss their patients' objections to AZT therapy as "psychological", as short-term depression or anxiety. The loyalty of the doctor should be to Retrovir ("the treatment") rather than to the patient ("the disease"). The hidden message to doctors is that they should not hesitate to kill their patients.

The hidden message to gay men is this: "You are doomed. Be brave, willing sacrificial victims. People will applaud you, and laugh at your jokes. Do not listen to the messages of your body."

Who is responsible?

Unscrupulous pharmaceutical companies, corrupt government officials, venal physicians, stupid and cowardly media people, incompetent and dishonest researchers-none

of these things are new. They are business as usual. Where, then, does the buck stop? Who is responsible for pharmacogenocide?

My thinking on this question was altered recently when I read *Confessions of a Medical Heretic* by Robert Mendelsohn, who uncompromisingly places the blame on the members of his own profession: Despite the obvious corruption of the drug company/doctor marketing connection, I don't blame the drug companies, the detail men, the government agencies which are supposed to police these activities, or the patients who badger their doctors for drugs. Doctors have enough facts in their possession to know what's going on. Even where the drug is fully tested and the side effects and limitations of the drug are well known, most of the harm is done by doctors indiscriminately prescribing the drug. Doctors, after all, are the ones who claim the sacred power and the ethical superiority that goes with it. The drug companies are in business to make money, and they do that by selling as much of their product as they can at as high a price as they can. And although the drug companies subvert the scientific process through which drugs are tested, certified, and made available to doctors, once the drugs are available, they do let doctors know-albeit subtly-just what these drugs can and cannot do.

All of us who know the truth about AZT will have to do what we can. Friends who are on AZT must be told directly and forcefully that they must get off the drug if they want to live. Public health officials, representatives of AIDS organizations, and various and sundry other "AIDS experts" must be confronted with their lies. Above all, doctors must be told that they have no right to prescribe a drug that can only lead to the deaths of their patients. The buck stops with the AZT-pushing doctors. They are responsible.

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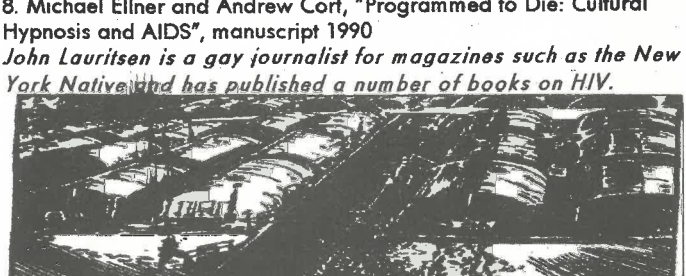
8. Michael Ellner and Andrew Cort, "Programmed to Die: Cultural Hypnosis and AIDS", manuscript 1990

John Lauritsen is a gay journalist for magazines such as the New York Native and has published a number of books on HIV.



AIDS WORDS FROM THE FRONT

By Celia Farber

Spin April 1997

The mainstream media has all but declared the AIDS epidemic over. But some experts wonder whether the new "cocktail" therapy craze is bad science and wishful thinking.

The story has rippled through every major news media outlet since last fall: Prescription-drug "cocktails" are having such a dramatic impact on AIDS that the very nature of the disease is being reversed. People are now springing back from their deathbeds, worried now not about dying but about living – about credit card balances and career prospects and life insurance policies already sold. Having spent all those years preparing to die, some people found the idea of living almost unsettling. Jornalist Bruce Mirken quoted an activist friend who dubbed this new journalistic phenomenon "I'm-Gonna-Live-and-I-Have-Nothing-to-Wear." Newsweek's cover asked whether this was "The End of AIDS?" Time named Dr. David Ho, the virologist who paved the way for the current drug revolution, as the Man of the Year.

Two articles in particular played major roles in launching the new optimism, because they were written by HIV-positive journalists who are themselves taking the drugs: Andrew Sullivan, former editor of the *New Republic*, wrote a lengthy personal essay for the *New York Times Magazine* entitled "When Plagues End -Notes on the Twilight of an Epidemic," and David Sanford of the *Wall Street Journal* penned a front-page article heading "Last Year, This Editor Wrote His Own Obituary."

Sullivan's article triggered a firestorm of jubilation mixed with fury. The essay explored Sullivan's own experience with AIDS – the deaths he witnessed, the fear he's felt, the onslaught of grief that anybody involved in this epidemic goes through – but the occasion of the article was the new pharmaceuticals. People are now taking a total of nine different drugs in any more than 100 combinations. Sullivan, despite all the qualifiers in his piece, is a believer. "The power of the newest drugs, called protease inhibitors," he wrote, "and the even greater power of those in the pipeline, is such that a diagnosis of HIV infection is not just different in degree today than, say, five years ago. It is different in kind. It no longer signifies death. It merely signifies illness."

Richard Berkowitz, a gay writer living in New York City who has been HIV-positive for more than a decade, descibed the streets of Greenwich Village on November 10, the day Sullivan's article was published: "I went to a gay cinema, and almost everybody had a copy. Everyone was talking about it. People were calling their mothers, weeping. Seeing those words on the cover of the *New York Times* like that was almost biblical. The desperation to believe it is so huge."

Science reporter Jon Cohen, who is skeptical about the new drugs, was one of the most prominent voices to assail Sullivan. In the online magazine *Slate*, Cohen insisted that only a vaccine could signal the end of AIDS: "Never in the annals of medicine has aviral plague been stopped by any therapy."

For his part, Sullivan feels his intended message was misconstrued. In an e-mail exchange with me, he wrote, "My Times piece was a first attempt to conceive of a world

after AIDS. It was titled 'When Plagues End,' not 'The Plague Has Ended.' It also talked about the end of a 'plague,' not the end of a disease. 'Plague' I define as something unstoppable, out of our control completely, affecting everyone indiscriminately. That phase clearly has ended, and it raises a host of fascinating and difficult questions."

All the stories - including Sullivan's - about the new drug combinations are laced with caveats: Some people "fail" on the drugs, and many can not afford them. But the core caveat is so monumental that it undermines the central premise. Time has not borne out whether the Lazarus effect of these new drugs will last. Rebounding from severe illness is one thing, "ending" AIDS is altogether another. All the data on the new cocktails are drawn from small studies, conducted over a period of weeks or, at most, months.

Yet Sullivan seems to believe that the resistance to imagining and end to AIDS is psychological, not scientific in nature. "I do think that Camus's insight that at the end of plagues some people refuse to accept it because they have come to need the experience emotionally is a profound one," he wrote me. "I know of no other disease where patient activists are so keen to tell people to avoid treatment."

Historically, in fact, "patient activism" in AIDS was built on a philosophy of "Drugs Into Bodies," meaning that people with HIV did not have time to wait and see whether drugs worked or not, but had to gamble. They did, and in the first round of gambling - with AZT - they undeniably lost.

This time around there is no consensus. For all the hype and excitement surrounding the new drugs, skeptical voices are heard all around. Both AIDS organizations and treatment activists have protested the hype emanating from the Vancouver AIDS conference last summer, which centered on Ho's announcement that he had used drug combinations to bring several patients down to "undetectable" levels of HIV, as measured by a so-called viral load test. Ho has expressed an "evangelical" zeal, in the *Wall Street Journal's* phrase, to get HIV-positive people on drug combinations as soon as possible. He has speculated that after two or three years of treatment, the virus might be eradicated and patients could go off the drugs.

There is no question that some people have rebounded from severe illness on the new drugs. But there is also no evidence that artificially lowering viral load by using drugs will improve health or lengthen life. "With sicker people, there's no question [that the new drugs work]. I've seen it myself," says Dr. Joseph Sonnabend, a cofounder of AmFAR. "But for healthy people? I have no idea whether it's going to hurt them or not, and yet they are being prescribed."

Meanwhile, the viral-load test has replaced the T-cell count as a barometer for illness. But is it a good one? As treatment activist Mike Barr recently reported in *POZ* magazine, the glossy AIDS monthly, an "undetectable" viral load merely means a number below an arbitrary cut-off point of 400 to 500 copies of HIV RNA per milliliter of blood. Some people have reached those levels on other drugs, like AZT and D4T, without getting any healthier.

The viral-load test iself is problematic. "I use this HIV viral-load test since it became available recently," says Dr. Donald Abrams, assistant director of the AIDS program at San Francisco General Hospital, "but I'm not convinced that I really, truly understand its correlation with clinical

outcome." One Los Angeles company that sells viral-load tests offered them for $10 during a trial period, as opposed to the $200 to $300 they normally cost. Activist Christine Maggiore, president of HEAL (Los Angeles), who is HIV-positive, took the test. So did Rodney Knoll, a friend of hers who is HIV-negative. (You generally have to certify that you are HIV-positive in order to take the test.) Astonishingly, the test results showed that Knoll had a higher viral load than Maggiore did.

"No one has shown that the viral-load test measures infectious virus," says David Rasnick, a scientist who specializes in various protease inhibitors. "They can't measure the actual virus because they can't find it. So instead they amplify [fragments of] viral RNA, and assume that that is the same as virus. It is not. The difference between RNA and the virus itself is the difference between a blueprint and a house."

The new drugs can be enormously difficult to take, logistically, even for those who can tolerate them (and afford them). There is an almost Orwellian term for this problem - "patient compliance," meaning How can we get these people to do what we need them to? Patients take handfuls of pills that can make them feel awful day and night, rearrange their lives so their stomachs are empty or full when it's time to take this or that drug. Quality of life? The adverse effects of the drugs are so voluminous it's almost absurd: kidney stones, vomiting, seizures, neuropathy, gastrointestinal disorders, excessive bleeding in hemophiliacs. There are more than 100 side effects listed.

There have also been scattered reports of people "crashing" on the new drugs and dying suddenly from acute liver toxicity. Ritonavir, the most toxic of the three currently available protease inhibitors, appears to have been associated with these deaths. The drug's maker, Abbott, even sent a letter to healthcare providers, warning of reports of liver dysfunction, "including some fatalities." A spokesperson for Abbott acknowledged that deaths have been recorded, but said that a "definitive causal relationship" had not been confirmed.

"I've heard every version - people swearing by these drugs and people writhing on the floor in agony," says James Scutero, founder of the largest online AIDS discussion group. He adds that enthusiasm about the current batch of protease inhibitors has "already peaked."

AIDS is in a state of suspension. There are striking parallels between the current cocktail craze and the emergence of AZT in the late '80s. "I suffer from historical perspective," says Abrams of San Francisco General, who rarely prescribes the new drugs. "I remember 1987, when AZT first became available. I was not convinced that it was the be-all and end-all. That stance was very unpopular, and then over the course of ten years more and more people started to come around."

Sean Strub, editor-in-chief of *POZ*, is living proof that the new therapies work wonders for some people. "I probably would be dead if these drugs hadn't come along," he tells me over lunch. "A year and a half ago, I had Kaposi's sarcoma in my lungs and was taking chemotherapy every two weeks. I had lesions all over my face. Then I started combinations and within weeks it turned me around." Today, Strub looks a little thin but otherwise healthy and has no visible lesions.

But Strub still does not believe that asymptomatic people

should take the new drugs. "I have so many friends who have waited - wisely so - with AZT. Those same cautious people are now going on cocktails. I try to stop them, but it's difficult." He can't help wondering if the parallels with AZT will be played out to a tragic conclusion. "My friends who were diagnosed at the same time I was, and who went on AZT, are virtually all dead today," he says. "Those of us who held out are alive."

Some AIDS researchers worry that the entire cocktail concept, and David Ho's underlying hypotheses about how HIV works, are based on sketchy research and unsupported data. "I'm totally ashamed of the profession," laments Sonnabend. "We have all these potent drugs but we don't know how to use them. If we were a sane society, we would find out. This is not evidence-based medicine. This is just a disgusting manipulation of people's fears and desperation, all for the sake of selling drugs."

Celia Farber is a journalist for Spin magazine and publishes a regular column questioning aspects of the AIDS orthodoxy.

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HOW GIANT DRUG FIRM FUNDS THE AIDS LOBBY

By Neville Hodgkinson

The Sunday Times (London) 30 May 1993

Wellcome, the giant drugs company that makes the controversial anti-AIDS drug AZT, is facing growing criticism over the pervasiveness of its influence on AIDS education, treatment and research. The company stands accused of using its unique position of power in the British medical establishment, via its close links with the Wellcome Trust, the world's richest medical research charity, to establish AZT as the "gold standard" of AIDS treatment, even though research suggests the drug is not the breakthrough it was thought to be.

As sales of AZT have grown last year reaching £ 213m the company has extended its own funding to a huge range of AIDS organisations, including a parliamentary group to which it has contributed £ 65,000. Critics say the result has been to foster a climate in which the anti-viral approach to AIDS has squeezed out almost all other lines of inquiry. This is despite scientific evidence from a recent Anglo-French trial, named Concorde, that AZT does not help in the early treatment of people who have HIV, and despite strong question marks over its safety and effectiveness in dealing with AIDS.

The issue is being taken up in parliament by George Galloway, Labour MP for Glasgow, Hillhead. "The British health service rolled over on its back for Wellcome, spending millions of taxpayers' money on this drug," he said. "In my opinion the health service has been well and truly shafted. The hegemony Wellcome have built up ... may turn out to be one of the greatest medical scandals of the century."

A campaigning group, the Steering Committee Against AZT Malpractice (SCAM), which wants the drug withdrawn, is holding a one-day inaugural conference in London next month at which Professor Peter Duesberg, a world expert on viruses, will participate. He argues that destructive lifestyle factors, especially drug abuse, are the commonest cause of AIDS in Western countries.

Another anti-AZT group, called Gays Against Genocide (GAG), is to picket the Great Ormond Street children's hospital in London on Wednesday to protest against the experimental use of AZT on HIV-positive babies. GAG has been picketing for six weeks the offices of the Terrence Higgins Trust, the most prominent AIDS charity, because it is annoyed that the trust has been producing pro-AZT papers with the company.

Wellcome rejects the criticisms, arguing that funding has not been confined to people who hold particular views on AIDS. Dr Martin Sherwood, group public relations manager, said: "I don't see that our support for community organisations is doing anything other than trying to get to a better understanding of disease management."

According to Martin Walker, a research worker who is to open next month's SCAM conference, part of the problem lies in the special relationship between the drugs company, known as the Wellcome Foundation, and the Wellcome Trust. He believes the trust's enormous power of patronage it has more than £ 200m a year for distribution helps to open doors at the highest level.

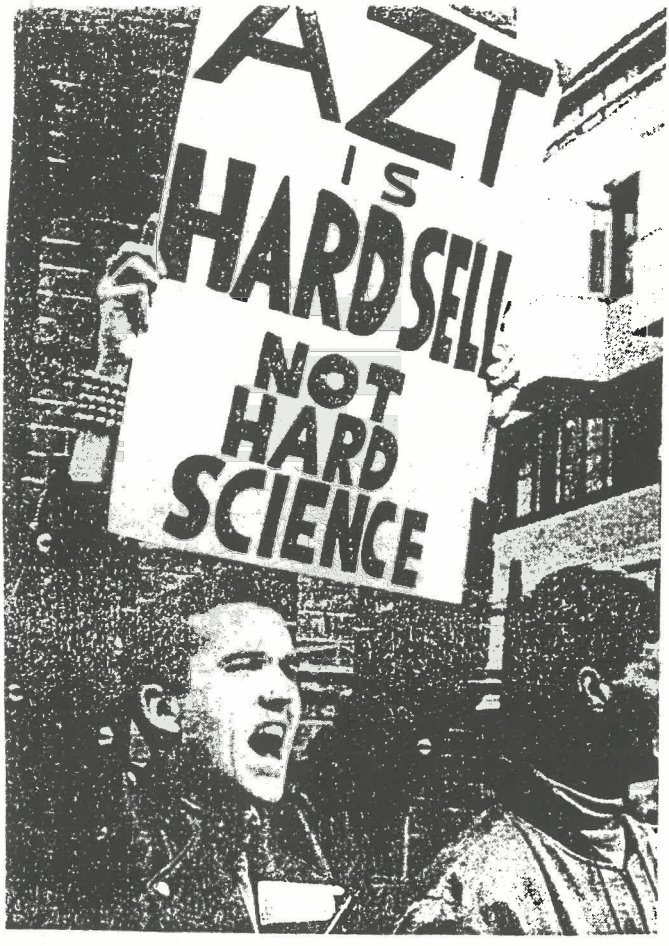
The trust is forbidden from supporting the activities of the company, and there is no suggestion that it has distorted its funding to benefit the firm. However, some of the trust's work has a direct bearing on HIV and AIDS. It recently set up the

Wellcome Centre for Medical Science, which this month ran an AIDS conference for teachers and school governors. The main scientific speakers were Professor Anthony Pinching, who conducted early AZT trials, and Professor Roy Anderson, a Wellcome grant recipient and a governor of the Wellcome Trust.

Walker's inquiries have shown that academic institutions at the forefront of AIDS research have been long-term recipients of trust money. These include the London School of Hygiene and Tropical Medicine and the University College and Middlesex School of Medicine. The trust is also funding an important study of sexual behaviour and lifestyles, one aim of which is "to provide data for ... mathematical models of the spread of HIV in the population". The study is being conducted through Imperial College, London, whose biology department is headed by Anderson. Anderson, an outspoken advocate of the view that AIDS is set to explode internationally, has contributed extensively to the work of the All-Party Parliamentary Group on AIDS, which has a membership of more than 150 parliamentarians. Over the past five years, the group has received £ 65,000 from the Wellcome Foundation, plus extra help for specific projects.

Another opinion-forming recipient of Wellcome Foundation cash is the British Medical Association Foundation for AIDS. It received a grant of £ 144,000 in 1988. The Wellcome Foundation helped the Terrence Higgins Trust to set up a fund-raising division, and backed production of four AIDS "health education" booklets. The first describes AZT as "the first drug shown to be effective against HIV". The fourth contains nine pages about the purported benefits of AZT. The foundation says in its annual report that it has been "active and imaginative" in promoting its products to opinion-leaders and prescribing physicians, and adds: "Through our work with HIV and AIDS groups in many countries, we are learning to communicate effectively with wider audiences."

Neville Hodgkinson is a journalist for the Sunday Tim es and other British mainstream newspapers.



Further Resources

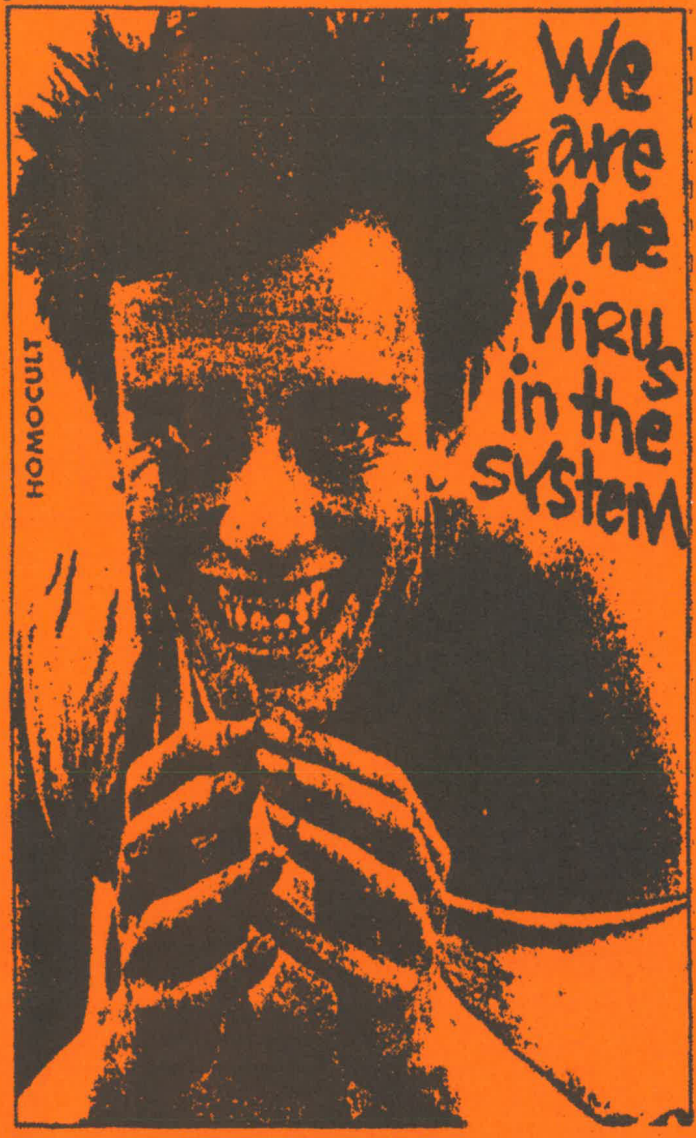
Websites

Rethinking AIDS- http://www.virusmyth.com
Questioning AIDS- http//www.duesburg.com
International AIDS Journalism Review- http//www.refuse-resist.com/iajr
AIDS Dissidence Info In Spanish- http//www.redestb.es/personal/freenews
Sumeria Health Website- http//www.livelinks.com/sumeria/aids.html

Magazines & Newsletters

Positive Health News- Alternative health and HIV dissidence newsletter.P.O. Box 27041, West Allis, WI 53227, USA.
Continuum- Scientific and health magazine from HIV dissidents and AIDS survivors. C/O 172 Foundling Court, Brunswick Centre, London, WC1N 1QE, UK.
Reappraising AIDS- Monthly newsletter of 'The Group for Scientific Reappraisal of the HIV/AIDS Hypothesis'. C/O 7514 Girard Ave, #1-331 La Jolla, CA92037, USA.
HEAL UK- Newsletter of the British chapter of "Health-Education- AIDS Liason" group. Information on holistic and alternative means to health and run primarily by AIDS survivors. C/O HEAL House, 375 Kensington Lane, London, SE11 5QY, UK.

There are also a number of good books about HIV dissidence and surviving AIDS. Refer to the websites or get in touch with the magazines above for more details.



Challenging The AIDS Myths.

"If there is evidence that HIV causes AIDS, there should be scientific documents which either singly or collectively demonstrate that fact, at least with a high probability. There is no such document."

Kary B. Mullis, Biochemist, 1993 Nobel Prize Winner For Chemistry.

"I would not be surprised if there were another cause for AIDS and even that HIV is not involved."

Walter Gilbert, Prof. in Molecular Biology, 1980 Nobel Prize Winner For Chemistry.

"The sentence of death accompanying the medical diagnosis of AIDS should be abolished."

Dr Alfred Hasig, Emeritus Prof. of Immunology at the University of Bern, former director of the Swiss Red Cross Blood Banks.

"The HIV-Causes-AIDS dogma represents the grandest and perhaps the most morally destructive fraud that has ever been perpetuated on the young men and women of the western world."

Dr Cgarles Thomas, former Professor of Biochemistry at Harvard University.

It is high time we reevaluated our ideas on what causes AIDS. Increasing numbers of health practioners, researchers and scientists across the world are doing this, yet the mainstream media and medical systems continue to buy into the HIV=AIDS=DEATH formula prescribing and recommending toxic, deadly drugs. This pamphlet brings you some of the voices challenging the AIDS orthodoxy as well as providing information on surviving AIDS.

Barnacle Books, 1998.